# Facility Abuse/Neglect Investigation Training

Virginia Department of Behavioral Health & Developmental Services

# Purpose

- To ensure facility investigators are equipped with the knowledge to effectively perform their duties.
- To ensure consistent statewide implementation of Human Rights Regulations and DI-201.
- To provide an overview of investigation process.

# Agenda

- Human Rights Overview
- Key Terms
- Departmental Instruction 201
- The Investigation Process
- Next Steps

# OHR Responsibilities

- Guarantee individual's rights protection
- Monitor provider compliance with the Human Rights Regulations
  - The *Regulations* can be accessed through Virginia's Legislative Information System (LIS) at https://law.lis.virginia.gov/admincode/title12/agency35/chapter115/
- Provide education and guidance to providers

# Human Rights Regulation: *12VAC35-115-30. Definitions*

**Abuse**: Any act or failure to act by any employee or other person responsible for the care of an individual … that was performed or was failed to be performed *knowingly, recklessly, or intentionally*, and that caused or might have caused physical or psychological harm, injury or death to a person receiving care or treatment for mental illness, intellectual disability or substance use disorder.

# Examples of Abuse

- Rape, sexual assault, or other criminal sexual behavior
- Assault or battery
- Use of language that demeans, threatens, intimidates, humiliates
- Use of excessive force when utilizing a physical/mechanical restraint
- Use of physical or mechanical restraint that is noncompliant with laws, regulations, policies, standards of practice, or the ISP
- Use of more restrictive, intensive services, or denial of services, to punish or that are not consistent with the ISP

# Categories of Abuse

SEXUAL

EXCESSIVE FORCE

PHYSICAL

VERBAL

# More on Abuse

**Exploitation:** The misuse or misappropriation of the individual's assets, goods, or property; and, the use of a position of authority to extract personal gain from an individual.

# Human Rights Regulation: *12VAC35-115-30. Definitions*

**Neglect**: Failure by a person, program or facility operated, licensed, or funded by the department responsible for providing services to do so, including nourishment, treatment , care, goods or services necessary to the health, safety and welfare of a person receiving care or treatment for mental illness, intellectual disability or substance use disorder.

# Examples of Neglect

- Failure to take actions that would have prevented an injury
- Failure to stop or try to stop an individual from an activity that could lead to harm
- Failure to report a co-worker not doing their job
- Failure to report inappropriate activity between individuals and staff
- Allowing two individuals to fight without intervening

# Human Rights Regulation: *12VAC35-115-30. Definitions*

**Time out:** Involuntary removal of an individual by a staff person from a source of reinforcement to a different, open location for a specified period of time or until the problem behavior has subsided to discontinue or reduce the frequency of problematic behavior.

**Seclusion:** Involuntary placement of an individual alone in an area secured by a door that is locked or held shut by a staff person, by physically blocking the door, or by any other physical or verbal means, so that the individual cannot leave it.

# Human Rights Regulation: *12VAC35-115-30. Definitions*

**Restraint**: the use of a mechanical device, medication, physical intervention, or hands-on hold to prevent an individual from moving his body to engage in a behavior that places him or others at **imminent risk**.

There are three types of restraint:

- Mechanical
- Pharmacological
- Physical

# Therapeutic Options of Virginia

- TOVA – the Department's approved program for behavior intervention and management.
- TOVA is a program to ensure safe implementation of behavior management techniques in the behavioral health milieu.
- DI 104
- Each facility has trained TOVA instructors.
  - The investigator should utilize the certified trainer as a resource during investigations.

# Human Rights Regulation: *12VAC35-115-175. Complaint Process*

- All allegations of abuse & neglect must be reported to the OHR, **and the AR**, within **24 hours**.
- Immediately ensure the individual's protection throughout the investigation.
- The **investigator must be trained** to conduct abuse & neglect investigations.
- The investigation should **begin as soon as possible,** but **no later than the next business day**.
- Document the results of the investigation in CHRIS within **10 working days**.
- The director will make the final decision and submit the findings.

# Complaint Process: *Hearing & Review Procedures*

## Local Human Rights Committee

- 12VAC35-115-180
- Provides due process for individuals
- Responsible for conducting fact-finding hearings in response to appeals
- Provides recommendations to the Facility Director

## State Human Rights Committee

- 12VAC35-115-210
- Provides oversight to the LHRC
- Hears and renders decisions on appeals for cases heard, but not resolved at the LHRC level

# CHRIS

- The Department's web-based reporting system for allegations of abuse and human rights complaints
- Per 12VAC35-115-230. Provider Requirements for Reporting, all providers must report allegations of abuse and neglect, as well as complaints against the regulations
- Allows for OHR staff to monitor investigations


TIME FOR A BREAK!


# Departmental Instruction *201(RTS)03*

# Purpose & Background

- The DI 201 outlines the policy, procedures, and responsibilities for reporting and investigating abuse and neglect.
  - The facility is responsible for maintaining a safe and secure environment.
- All allegations of abuse and neglect at DBHDS-operated facilities will be investigated.
- In response to allegations of abuse and neglect, action must be taken to prevent future occurrences.

# Responsible Authority

- The **State Human Rights Director** (SHRD), or designee, is responsible for:
  - Interpreting DI 201
  - Consulting regarding the  implementation of DI 201
  - Assisting with identifying incidents requiring investigation
  - Reviewing data, and reporting concerns to the Advisory Panel and Commissioner

# Responsible Authority

- The Central Office Abuse Neglect Advisory Panel is responsible for:
  - Reviewing, making recommendations concerning investigations referred to the panel
  - Referring recommendations concerning quality and risk to the Facility Director and appropriate assistant commissioner, within 48 hours of review
    - Systems issues and trends are reported to the Department's Quality Improvement Committee

❖ All review requests should be made via email, to the SHRD, after the Facility Director has consulted with their supervisor.

# Responsible Authority

- **Facility Directors**
  - Ensure employees are trained and implement DI 201
  - Ensure employees named in allegations are presumed not to have committed abuse/neglect
  - Ensure facility compliance with all applicable state laws
  - Appoint trained investigators

- **Facility Advocates**
  - Monitor the investigation process to ensure rights of individuals are protected
  - Review the investigators findings
  - May conduct an independent investigation
  - Notify SHRD if investigation findings are inconsistent with DI 201
  - Review and issue investigation extensions if warranted

# Responsible Authority

**Facility Investigator:** a person who successfully completed investigative training and has received a certificate of completion by the Department.

- A Facility Investigator shall:
  - Be appointed by the Facility Director
  - Conduct an impartial investigation
  - Render an investigation summary to the Facility Director and Facility Advocate within 10 working days unless an extension has been granted by the Facility Advocate

# Specific Guidance

- The DI applies to the entire workforce.
  - classified employees, wage employees, contract employees (including locum tenens), temporary employees, volunteers, student interns, and consultants.

- Workforce protections are afforded as a result of an abuse/neglect allegation. The workforce shall:
  - Be informed of the investigation and be advised that an impartial investigation will be conducted.
  - Have rights explained (relative to the DI 201).
  - Receive written notification of the investigation findings.
  - Be allowed to present evidence during and after the investigation.

- There is a presumption of innocence until a determination is made by the Facility Director

# Specific Guidance

- Substantiating Abuse and Neglect
  - A finding of abuse or neglect shall be substantiated by a preponderance of the evidence gathered during the investigation process as determined by the Facility Director.
- Release of Information
  - All requests for information regarding abuse/neglect shall be routed through the Facility Director.
- Personnel Actions
  - All personnel actions, including grievance resolutions, shall be reported to the department's assigned human resource consultant.


Questions

# Reporting Requirements

- The Facility Director shall be notified in all cases.

- Workforce members may, and shall, when required by law, also directly notify the appropriate protective services agency:
  - Child  Protective Services – for children under 18 years of age.
  - Adult Protective Services – over age 60 or incapacitated.

If abuse/neglect is suspected, it shall be reported within 24 hours.

# Receipt of the Allegation

The investigator will review the following on the DBHDS Form 201A for each incident:

1. The reporting person has completed all appropriate blanks
2. The Facility Director's office has dates and times entered for the required notifications
3. There is an incident category and a code
4. Verify that no more than one incident is contained on each 201A Form

# Initial Investigation

- Upon receipt of an allegation, the Facility Director shall immediately ensure:
  - Protection of the individual(s).
    - May involve suspension or relocation of the accused workforce member.
  - Protection of physical evidence.
  - Within 24 hours:
    - Initiation of an impartial investigation conducted by a trained investigator.
    - Notification to the individual (and AR) that the investigation has begun, and the investigation process.
    - Notification to the OHR via CHRIS.
    - Notification to DSS (as required by Va. Code)
    - Notification to workforce about required cooperation and not to discuss facts with anyone other than the investigator(s).

# Initial Investigation

- The Facility Director shall immediately contact local law enforcement or the State Police Bureau of Criminal Investigation, or both, in all cases of suspected criminal activity. Law enforcement may choose to suspend the 201 investigation.

- The Facility Director and Investigator shall take immediate action, based on critical care issues of the individual receiving services, to determine whether there is a need to secure evidence or sequester clinical records while ensuring that appropriate treatment occurs.

- The Investigator shall immediately inform the Facility Director and the Facility Advocate if a conflict of interest could compromise the integrity of the investigation. If a conflict does exist, the Facility Director shall take appropriate action to resolve the conflict.

# Repetitive and Improbable Allegations

- **ALL** allegations of abuse or neglect must be investigated.
- An improbable allegation is one that may be based on inaccurate information.
- For an allegation to be deemed improbable:
  - There must be consultation with the treatment team to determine whether the inaccurate information is symptomatic of the individual's illness or disability
  - A thorough clinical assessment must conclude the allegation is improbable

# Repetitive and Improbable Allegations

- If the allegation is determined to be improbable, no further investigation is needed and the case closed as unsubstantiated; however:
  - the investigator must submit a report explaining the rationale for the improbable finding
  - the Facility Director must maintain the supporting documentation
- If the Facility Director, Investigator, or Facility Advocate believe further investigation is warranted, the investigation must continue.

# Examples of Improbable Allegations

- Allegation that the individual was incarcerated by the Facility Director this morning.
- Daily allegation that “I was raped last night.”
- “The CIA is training me to be a spy, and are torturing me at night.”

# Timeframe for Investigation Completion

The Investigator assigned to a case shall ensure completion of the investigation **summary** report within the following prescribed timeframes:

- **5 working days** of assignment of a case for all allegations that must be reported to the Department of Health (for Medicaid or Medicare certified facilities).

- **10 working days** of assignment of a case for all other allegations unless the Commissioner or any regulation requires a shorter timeframe.
  - Requests for extensions must be submitted to the Facility Advocate within 6 working days and should be maintained in the investigative file.
  - Investigations may be suspended at the direction of law enforcement.

# Investigation Conclusion

- The Investigator shall:
  - Submit a signed and dated investigation summary report, with all documentary evidence included to the Facility Director and the Facility Advocate.
  - Brief the Facility Director and Facility Advocate in order to provide additional information or comments and obtain feedback regarding the investigation findings.

- The Facility Advocate shall:
  - Provide feedback to the investigator regarding human rights issues.
  - Submit the results of any independent investigation to the SHRD and Facility Director.
  - Provide technical assistance when an individual disagrees with the director's decision and seeks to request an LHRC hearing.

# Investigation Conclusion

- The Facility Director shall:
  - Decide whether abuse or neglect occurred.
  - Request an extension up to 3 days (unless certification timeframes prevent this) allowing the accused employee an opportunity to present information on their own behalf.
  - Implement any actions required to address any findings or recommendations and proceed to close the investigation in accordance with procedures in Section 9 of DI 201.
  - Seek consultation from the appropriate Assistant Commissioner and, if needed, the Central Office Abuse Neglect Advisory Panel if the general consultation is needed or if the case or findings may be considered controversial or subject to media coverage.

# Investigation Closure

- When the investigation is closed, the Facility Director or designee shall:
  - Provide written notification of the final decision and action plan, and the individual's right to appeal.
  - Take appropriate personnel actions as outlined in the department's Employee Handbook, Chapter 14, in accordance with the findings of the investigation.
  - Implement and track any appropriate administrative or clinical care and treatment-related actions in order to prevent future occurrences of abuse or neglect.
  - Notify the Department of Social Services, Virginia Department of Health Professions, other professional licensing agencies, other regulatory agencies.
  - Ensure that all required information about the investigation is entered into CHRIS.
  - Provide the workforce member the opportunity to discuss the investigations process and outcomes when a case is unsubstantiated.

# Closing Substantiated Cases

- The Facility Director is responsible for implementing and tracking any appropriate actions in order to prevent future occurrences of abuse or neglect.

- A Substantiated Investigation is considered closed when the Facility Director:
  - Takes any necessary disciplinary action;
  - Develops any other appropriate corrective action plan; and
  - Writes a letter of closure.

- Any actions taken shall be developed in consultation with the Facility Advocate and other appropriate personnel.

# Closing Unsubstantiated Cases

- The Facility Director determines whether abuse or neglect occurred based on the findings of the investigation and shall decide whether an administrative intervention is necessary.

- The Facility Director may also seek consultation from appropriate Central Office staff in making this determination.

- An Unsubstantiated Investigation is considered closed upon the Facility Director's receipt of a transmittal letter and investigative summary from the Investigator.
  - This letter may include recommendations for further administrative action.

# Closure with Administrative Issues

The Facility Director shall address any administrative issue identified by the Investigator that is **specific to the case findings**. This shall be accomplished by:

- Taking corrective action
- Reporting that such action was taken to the Facility Advocate
  - A description of these actions shall be maintained in the case file.

# Advocate Review

- All investigations shall be submitted for review to the Office of Human Rights through CHRIS. The review will determine whether:
  - The presentation of facts and the conclusion is expressly stated and properly supported by the findings presented.
  - Complaints are investigated appropriately while considering the severity and threat to the individual.
  - Appropriate actions were taken at the facility level to protect the health, safety, and welfare of the individual.
  - Evidence was protected.
  - The allegation was properly and thoroughly investigated.
  - The facility investigator has the necessary report writing skills.
- Upon completion of this review, if the Facility Advocate has concerns regarding the findings of the Investigator or the final determination of the Facility Director, the case file shall be forwarded to the SHRD for review  by the Central Office Abuse and Neglect Advisory panel.

# Individual Right to Appeal

- If the Individual or his AR disagrees with the Facility Director's final decision and action plan, they may request an LHRC Hearing within 10 working days of receipt of the Facility Director's action plan or final decision.
- The LHRC, and possibly SHRC, will make a determination about whether or not there was a violation of 12 VAC 35-115-50(B)(2) based on facts presented.
  - These bodies may also make recommendations to the Facility Director on the development of the action plan.
- If the Facility Director's decision and LHRC or SHRC decision are different, the investigation summary/findings will not be changed.
  - Only the Facility Director's final decision and action plan are subject to the appeal process.


QUIZ TIME

# Prioritizing Caseloads

**The Investigator shall ensure that the most serious incidents are handled in a timely manner.**

- Each investigator shall prioritize their cases in the following order:
  - Abuse/Neglect Cases where accused employees are on Annual Leave or Pre-disciplinary Leave With Pay pending determination of the investigation, shall be completed within ten (10) work days.
    - Extensions must be approved by the Facility Advocate.
    - **Exception**: Calls to the scene of an incident will cause temporary shifts in priorities to immediately ensure the preservation of evidence as needed.

# Case Numbering of Incidents

- POLICY: The Facility Director will designate a person responsible for assigning case numbers to incidents/allegations meeting reporting criteria. When in doubt about specific cases, the designee may consult with the Facility Advocate prior to assignment of a case number.

- PROCEDURE: Numbering for incidents
  - Case numbers assigned by the Department-operated facility will be sequential in the following format:

| 01 | 2000 | 001 |
|---|---|---|
| (Facility Code) | (Calendar Year) | (Sequential Number) |

# Related Events Composing A Single Incident

- **Related events at the same approximate time**:
  - Fred Jones alleged that employee Mike Dott hit him and then cursed at him yesterday during showers.
- **Related events at the same location:**
  - Fred Jones alleged that employee Mike Dott hit him before showers yesterday and then cursed at him after showers.
- **Related events at the same approximate time and location involving multiple victims:**
  - Fred Jones and Bob Johnson alleged that employee Mike Dott hit them and cursed at them yesterday during showers.
- **Related events at the same approximate time and location involving multiple perpetrators:**
  - Fred Jones alleged that employees Mike Dott and Julie Williams hit him and cursed at him yesterday during showers.

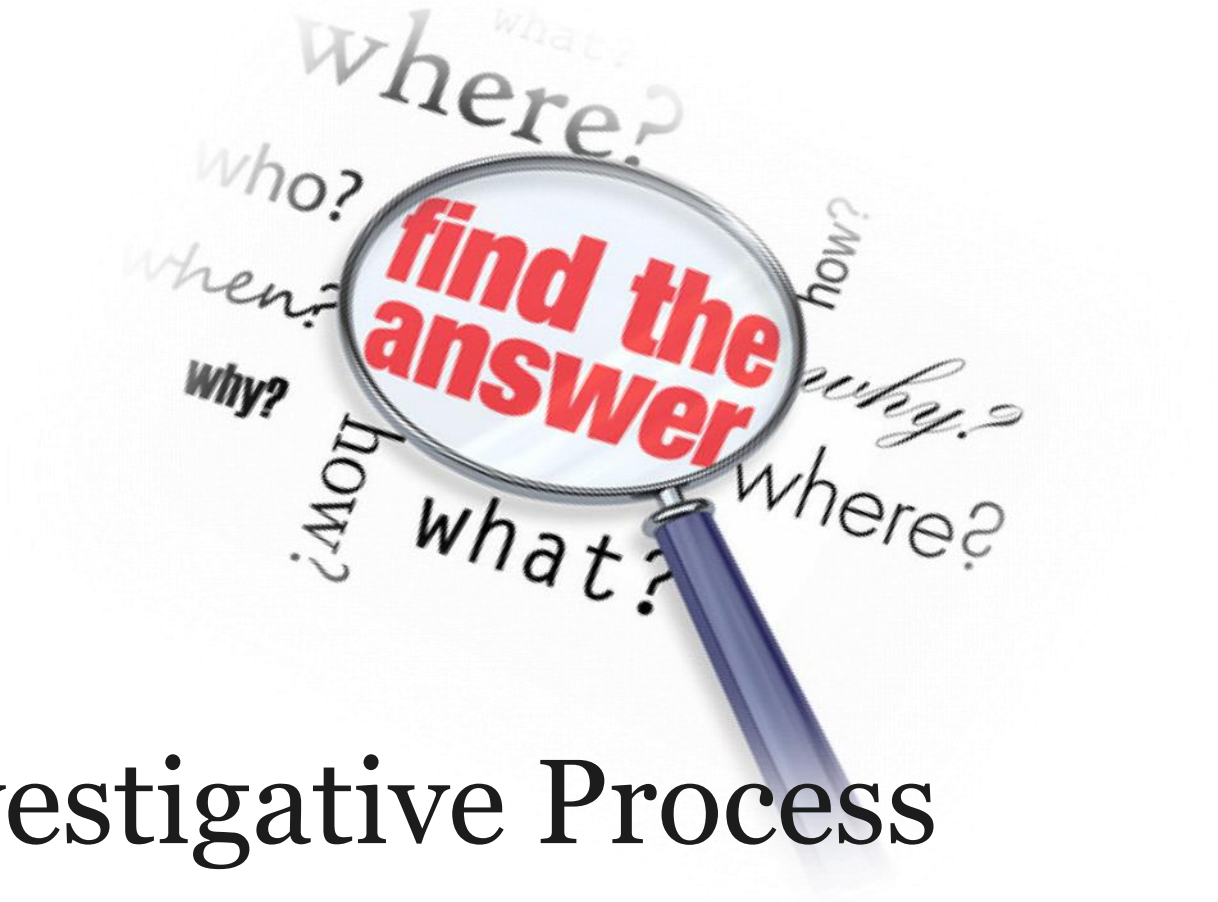
# Events Composing More Than One Incident

- **Related events not at the same approximate time or location:**
  - Fred Jones alleged that employee Mike Dott hit him during showers and employee Julie Williams hit him during breakfast.

- **Unrelated events at the same approximate time or locations:**
  - Fred Jones alleged that employee Mike Dott hit him yesterday during showers for not cleaning his room and that employee Julie Williams cursed at Bob Johnson for being slow**.**

- **Unrelated events not at the same approximate time or location:**
  - Fred Jones alleged that employee Mike Dott hit him yesterday during showers and that employee Julie Williams cursed at him this morning during breakfast.


KEEP
CALM
IT'S
LUNCH
TIME




# The Investigative Process

# Defining Investigation

- An investigation is a "systematic collection of facts" that assists in understanding an incident.
- Facts are pieces of information that contribute to some sense of certainty; and, help generate conclusions.
- Formation of the investigatory question helps the investigator determine which facts will be relevant to the investigation.
- Facts lead to the collection of evidence, or information that may help describe and/or explain what happened.
  - 4 forms of evidence
  - 2 types of evidence

# The Investigatory Question

- It is imperative to develop the investigatory question as it is the compass of the investigation.

- Information obtained verbally and/or through the initial written report provide crucial elements for the construction of the investigatory question:
  - When the incident happened (**time**)
  - Where the incident happened (**space**)

- The investigatory question should be formed so that it describes the when (time) and where (space) of the allegation.

# Forming the Investigatory Question

- Forming the question:
  - Make the question open-ended
  - If the time and space of the incident is not known, include an approximate reference to these factors
  - Verbiage should be concrete
  - Avoid concluding the facts
  - The question should not be disputable
  - It is acceptable to revise the question, if needed, when new information is obtained
- Allow the investigatory question to do its job – let it lead the investigation.

# Let's Practice

# Sample Allegation

While transitioning from the recreation area to Unit 3A for lunch, Peer A and Peer B engaged in a physical altercation as reported by Peer C. Peer B reportedly called Peer A a derogatory name. Peer A responded by punching Peer B in the face. Peer B fell to the ground and hit his head. DSP John, reportedly on his personal cell phone at the time, responded to the scene due to hearing the altercation. DSP Dan reportedly stayed back in the recreation area to smoke a cigarette. DSP John called a code and provided first aid.

# Organizing the Investigation

- Observe, review the scene at the time of arrival
- Interview the person making the report
- Collect physical evidence
  - Create demonstrative evidence if unable to preserve the physical evidence (e.g., diagrams, photos)
- Interview the victim
- Interview the other direct evidence (eyewitnesses)
- Interview the circumstantial evidence witnesses
- Interview the alleged target of the investigation
- Collect documentary evidence for review later

# Defining Evidence

- Preponderance of the Evidence
  - Based on the facts gathered, the allegation is more likely to have occurred than not.
  - 50.01% or greater
- Forms of Evidence
  - Testimonial
  - Documentary
  - Physical
  - Demonstrative
- Types of Evidence
  - Direct
  - Circumstantial
- All evidence must be kept for 5 years, including the investigator's case file.

# Physical Evidence

- It is important to collect and/or preserve early.
- Physical evidence should be collected prior to interviewing witnesses.
- Collection procedures:
  - Ensure the chain of custody protocol is followed.
    - Begins at the time the scene is secured.
    - Tag/label all physical evidence collected.
      - Include the item description, date, place & time collected, who collected the item.
      - Number or letter each item collected. Consider including the CHRIS number, too.

# Physical Evidence

- Injuries are an important piece of physical evidence:
  - They should be seen, photographed (when possible).
  - The alleged victim should receive medical attention, or first aid depending on the seriousness of the injury.
  - The investigator should obtain and review any relevant medical records.
  - If there is an alleged perpetrator, check that person for injuries, too.
  - Allow medical professionals to assess injuries and make a diagnosis.

# Demonstrative Evidence

- This is how physical evidence is preserved.
- Take pictures and draw a diagram of scene.
- Make sure that all demonstrative evidence is labeled according to the internal protocol.
- Ensure to review video footage, if available.

# Demonstrative Evidence: *Photographs*

- Photographs are helpful in cases involving any visible injury related to an allegation of physical abuse.
  - digital cameras preferred
  - you must have consent to photograph the client
  - you should have secure logging of the photographic evidence
  - photographs are not to be viewed by others who are not authorized to do so

*The investigator is responsible for ensuring that photographs are maintained securely*

# Testimonial Evidence

- Testimonial evidence, or a witnesses recollection of the allegation, is the most commonly available forms of evidence.
- Effectively collecting testimonial evidence is important to the investigation.
- Interviews should not be aggressive or accusatory.
- Types of Interviews
  - Incident
  - Exploratory
  - Background
  - Follow-up

WE DO NOT CONDUCT INTERROGATION INTERVIEWS

# Testimonial Evidence: *Preparing for the Interview*

- The investigator must be prepared to conduct each interview:
  - As much as possible, ensure the witnesses have been separated (or remain separated) until being interviewed.
  - Observe the scene of the alleged incident first.
  - Create an outline of the topics/areas to be discussed.
    - Do Not pre-write questions.
  - Check your attitude.
  - Identify the reason for the interview.
  - Identify an appropriate setting to conduct the interview.

# Testimonial Evidence: *Conducting the Interview*

- In conducting an interview, the primary goal is for the interviewer (investigator) to elicit relevant information from the witness.
  - The goal is **not** to lead the witness to **confirm** the **investigator's beliefs**.

- A successful interview is like putting together pieces of a puzzle. Think of the following as the four corners of the puzzle:
  1. The investigator must be sure of, and be able to effectively communicate to the witness, the purpose of the interview.
  2. The investigator must ask relevant questions.
  3. The witness needs to understand the purpose and be a willing participant in the interview process.
  4. The investigator has to be willing to acknowledge and accept the information the witness presents, orally and nonverbally.

# Testimonial Evidence: *Closing the Interview*

- Summarize the facts/observations solicited from a witness.
- Get his/her agreement with the summation and accept any corrections.
- Tell them not to discuss the event or their interview with others.
- As appropriate, tell them what will happen next.
- Ask if they have any final questions or comments.
- Tell them they may contact you if they have anything else to offer.

# Testimonial Evidence: *Reconciling Conflicting Testimony*

- All things being equal, a witness' story is more credible (accurate) if:
  - He or she has told the **same** story consistently.
  - There is **independent corroboration** for the story.
  - The story is **consistent with the physical evidence**.
  - The person had **no perceptual or physical impairment** that would affect his or her ability to **observe** the incident.
  - The person had been **paying attention** – i.e. was **focused**.
  - The person's **objectivity was not compromised** by having a **personal interest** in the case.

# Testimonial Evidence: *The Uncooperative Witness*

- Reasons:
  - A belief that it is not appropriate to help management b/c the goal is to blame even if there is no guilt
  - Conflict of interest
  - The person being interviewed believes he may be disciplined
  - Genuine misunderstanding or fear of the process

- Support the witness:
  - Remind of requirement to cooperate (employees)
  - Remain on target, objective
  - Be patient
  - Ensure language is clear, direct

# Documentary Evidence

- Collect documentary evidence after collecting physical evidence.

- Types of documentary evidence include:
  - Witness statements
  - Internal protocols/procedures
  - Individual chart records

# Documentary Evidence

- Ensure the following related to witness statements:
  - Interview witnesses prior to taking a written statement.
  - Remain with the witness as they write their statement.
  - Do not edit a witnesses statement for grammar, spelling.
  - If a witness is unable to read/write:
    - The investigator may write the statement as the witness provides their answer/account to questions;
    - Then, ask another individual (not involved in the investigation) to join the interview and read the statement to the witness, ensuring to ask the witness if the statement is accurate.

# Documentary Evidence

- Additional factors to ensure regarding witness statements:
  - Statements that are not legible should be typed.
  - After the witness reads their statement, obtain the witness' signature.
    - Make sure the witness initials and dates any changes they make to the statement.
  - Include when, where the statement was taken, who took the statement, the name/title of the witness, & investigator's signature.

# Documentary Evidence: *Written Statements*

| Method | Advantage | Disadvantage |
|---|---|---|
| Audio tape | Most Perfect record | Intimidating and requires extra equipment plus transcription |
| Taking notes during the interview | Efficient and requires no additional equipment except for a pen and paper | Distracting to the witness<br>Not the witness's statement but the interviewer's interpretation of the witness's statement |
| Interview first, then re-interview the witness, asking that he or she write the statement in response to your questions | Very perfect record in the witness's own handwriting<br>Requires no additional equipment except for a pen and paper | Time consuming and tedious for the witness |

# Reminders About Evidence

- Evidence requiring further analysis will be coordinated through the Virginia State Police.
- Evidence is to be maintained for a minimum of five years along with the investigator's case file.
- When appropriate, all perishable evidence may be destroyed after photographs are taken and verification of quality prints have been made.


TIME FOR A BREAK!

# The Investigator's Summary

- After concluding the investigation, a report of the findings must be written.
  - The report must be maintained as part of the individual's record.
  - A summary of the report is to be documented on the Investigation page in CHRIS (see 12VAC35-115-230(A)(3))
- Additionally, 12VAC35-115-230(A)(3)(a.-c.) states that the report should contain:
  - Whether abuse, neglect, or exploitation occurred;
  - The type of abuse; and
  - Whether the act resulted in physical or psychological injury.

# The Investigation Summary: *Basics of a Well Written Report*

- **FACTUAL**
  - Facts are statements that can be proven.
  - Ensure the separation of fact from opinion.
    - Opinions, or labels for behavior, are personal beliefs.
- **ACCURATE**
  - Document specific and detailed facts, and avoid generalizations.
- **OBJECTIVE**
  - Avoid biased language and judgment (e.g. words with negative connotations).

# The Investigation Summary: *Basics of a Well Written Report*

- **COMPLETE**
  - Who – Identify everyone involved accurately/completely.
  - What – Report the facts exactly as you learned them.
  - When – Document date, time, and the activity that was occurring at the time of the incident.
  - Time – Using standard time, distinguish between a.m. & p.m.
  - Where – Document the precise place the incident occurred, including where it started, moved to, and ended.
  - Why – If able, document the reason the incident happened.
  - How – Report how the incident started, progressed, and ended.

# The Investigation Summary: *Basics of a Well Written Report*

- **CONCISE**
  - Be direct and to the point.
  - Use simple language.
- **CLEAR**
  - Be specific and concrete in presenting facts.
- **MECHANICALLY CORRECT**
  - Be conscious of grammar and avoid slang.
- **LEGIBLE**
  - Type the report using standard font.

# Types of Findings

**Abuse/Neglect SUBSTANTIATED**

- Typically occurs when a preponderance of the evidence is amassed.
- The finding does not have to reflect the initial classification of the incident (i.e. the original allegation may have initially alleged physical abuse, which could not be substantiated; however, the evidence does support a finding of neglect).

**Abuse/Neglect UNSUBSTANTIATED**

- Occurs when there is not a preponderance of evidence, or insufficient evidence.
- However, additional findings can be documented (e.g. Inappropriate or Non-Therapeutic Behavior).
  - Appropriate when the facts as a whole do not warrant substantiation, but evidence exists that staff violated facility policy, practice, or procedure.

# Other Unsubstantiated Findings

- **Insufficient Evidence**
  - This determination is appropriate when the Investigator believes, and some facts support, that a violation may have occurred but a preponderance of evidence is not amassed.
  - However, evidence is sufficient to identify employee misconduct.

- **Administrative Issues**
  - This determination will typically relate to defective policies and procedures, systems issues, or misconduct by someone other than a facility employee.

# What's Your Recommendation?

While transitioning from the recreation area to Unit 3A for lunch, Peer A and Peer B engaged in a physical altercation as reported by Peer C. Peer B reportedly called Peer A a derogatory name. Peer A responded by punching Peer B in the face. Peer B fell to the ground and hit his head. DSP John, reportedly on his personal cell phone at the time, responded to the scene due to hearing the altercation. DSP Dan reportedly stayed back in the recreation area to smoke a cigarette. DSP John called a code and provided first aid.

Facts:

- Peer C saw Peer B punch Peer A in the face.
- Peer C, D, & E stated DSP John was on the phone while they walked to lunch, and DSP Dan stayed outside to smoke a cigarette.
- The policy states at least one staff must engage the group in sight/sound supervision during transitions.

# Grievance Hearings

- A formal process conducted under oath.
- Be prepared to discuss and answer questions about:
  - your investigatory process;
  - your recommendations; and,
  - specific language in the policies & procedures.
- Ensure your investigator's summary is complete and legible.
- Be mannerable and respect the formality of the process.

# Grievance Hearings

DEPARTMENT OF HUMAN RESOURCE MANAGEMENT
OFFICE OF EQUAL EMPLOYMENT AND DISPUTE RESOLUTION

101 N. 14TH Street, 12TH Floor Richmond, Virginia 23219

Toll Free 888-23-ADVICE

www.dhrm.virginia.gov/edr

# Facility Look-Behind Process

- The OHR began conducting retrospective reviews of closed abuse/neglect cases at state operated facilities in November 2017.
  - Purpose: To assess discrepancies between investigation information entered into CHRIS and information maintained in the investigation file.
  - Goal: To more effectively support the facility investigation process and improve outcomes reported to OHR.
  - Process: Facility Advocates complete a desk review of CHRIS followed by a physical review of the investigation file and investigator training certificate.


Questions

# Next Steps

- Practice with an experienced Investigator
- Access to shared resources
- On-going Support & Consultation
- LRA Certification
- Training Evaluation - Feedback

# Points of Contact

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# References

Code of Virginia § 37.2-100

Labor Relations Alternatives, Inc. (2016). *Investigations manual* (7th ed.). [Conducting Serious Incident Investigations].

Virginia Administrative Code § 12.35-115